Baltimore City Health Department SCHOOL HEALTH PROGRAM	Request to Administer Medication in School

To Parent/Guardian: To request medication administration at school please note:

- This form must be completed and signed by **you and your child's medical provider**.
- **A new form is needed for all medication, dose or time changes.**
- The medication **must** be brought to school by a parent/guardian or responsible adult.
- The medication container **must** be labeled by the pharmacy with the student's name, prescriber name, medication name, dosage, route, conditions for storage, prescription date and expiration date.
- The **first dose** of medication **cannot** be given in school, (except EpiPen, Glucagon).
- Expired and discontinued medication or medication not picked up by the last day of school will be destroyed.

Order for Medication in School (One medication per form)

Student _____ DOB_____ School _____ Grade ____

Diagnosis _____

Medication _____ Strength _____

Dose_____ Route _____ Time(s)**In School** _____

PRN _____ frequency_____ for what symptoms?_____

Side effects/Adverse Reactions/Allergies: (**circle) NO/YES** Specify: _____

_____

Medication should begin _____(date) and terminate _____end of school year
_____other – *DATE* _____

For Inhaler and Epi-Pen Medication Only:

____ It has been determined that this student is able to self-administer and carry an asthma inhaler or Epi-Pen, and has been trained in its use including knowing when the medication is to be used. It is the student's responsibility to report usage to the health suite staff.

____This student should **not** self-administer an asthma inhaler or Epi-Pen.

Physician/Prescriber Name (please print)_____ Date _____
Physician/Prescriber signature: _____Telephone _____
Address _____ Fax_____

Discontinue Medication (signature)_____ Date _____

I request and authorize Baltimore City Health Department (BCHD) school health staff to administer this medication in accordance with the above order. I agree not to hold BCHD staff responsible for any ill effects resulting from the administration of this medication.

Parent/Guardian Signature_____ Date ___/___/___
Parent Phone # _____ Emergency Phone # _____
Form received by school on ___/___/___ by _____
Reviewed/Transcribed by _____, R.N./L.P.N. on ___/___/___